KAMALA D. HARRIS
Attorney General of California
DIANN SOKOLOFF
Supervising Deputy Attorney General
SUSANA A. GONZALES
Deputy Attorney General
State Bar No. 253027
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 622-2221
Facsimile: (510) 622-2270
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **STEVEN OREN LUEDER** **2021 NW 15th Street** **Crystal River, FL 34428** **Registered Nurse License No. 600886** Respondent.	Case No. 2011-957 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about June 21, 2002, the Board of Registered Nursing issued Registered Nurse License Number 600886 to Steven Oren Lueder (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges alleged in this Accusation and will expire on August 31, 2011, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 118, subdivision (b), of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY AND REGULATORY PROVISIONS

7. Section 2761 of the Code states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

8. Section 2762 of the Code states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. Code section 4060 provides, in pertinent part:

"No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, [or] a physician assistant pursuant to Section 3502.1 . . ."

10. Section 11190 of the Health and Safety Code states, in pertinent part:

"(a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following: (1) The name and address of the patient; (2) The date; (3) The character, including the name and strength, and quantity of controlled substances involved."

11. Section 11192 of the Health and Safety Code provides that in a prosecution for a violation of Section 11190, proof that a defendant received or has had in his possession at any time a greater amount of controlled substances than is accounted for by any record required by law or that the amount of controlled substances possessed by a defendant is a lesser amount than is accounted for by any record required by law is prima facie evidence of a violation of the section.

12. Section 11173, of the Health and Safety Code states, in pertinent part:

"(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by concealment of a material fact.

"(b) No person shall make a false statement in any prescription, order, report, or record, request by this division."

13. Section 11350, subdivision (a), of the Health and Safety Code states:

"Except as otherwise provided in this division, every person who possesses (1) any controlled substance specified in subdivision (b) or (c), or paragraph (1) of subdivision (f) of Section 11054, specified in paragraph (14), (15), or (20) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055, or specified in subdivision (h) of Section 11056, or (2) any controlled substance classified in Schedule III, IV, or V which is a narcotic drug, unless upon the written prescription of a physician, dentist, podiatrist, or veterinarian licensed to practice in this state, shall be punished by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code."

14. Section 11208 of the Health and Safety Code states:

"In a prosecution under this division, proof that a defendant received or has had in his possession at any time a greater amount of controlled substances than is accounted for by any record required by law or that the amount of controlled substances possessed by the defendant is a lesser amount than is accounted for by any record required by law is prima facie evidence of guilt."

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

15. Code section 4021 states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

16. Code section 4022 provides:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only' or words of similar import.

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import . . .

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

17. Ativan is a brand name for Lorazepam, a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug pursuant to Code section 4022. Ativan is an anti-anxiety drug primarily used for the treatment of anxiety, tension, and anxiety with depression, insomnia, and acute alcohol withdraw symptoms.

18. Hydromorphone, also known as Dilaudid, is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(k), and a dangerous drug pursuant to Code section 4022. Hydromorphone is a hydrogenated ketone of morphine and is a narcotic analgesic. Its principal therapeutic use is relief of pain. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Hydromorphone should be prescribed and administered with caution.

19. Oxycodone with Acetaminophen, also known by Percocet or Norco, is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (b)(1)(N), and a dangerous drug under Code section 4022. Oxycodone is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused.

20. Morphine Sulfate is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug under Code section 4022. It is also a Schedule II controlled substance as defined by the Federal Code of Regulations, title 21, section 1308.12, subdivision (b)(1). Morphine, which is a central nervous system depressant, is a systemic narcotic and analgesic used in the management of pain.

COST RECOVERY

21. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL BACKGROUND

22. Respondent was employed by InteliStaf Medical Staffing Network, a traveler nurses' registry, as a registered nurse from May 2009, to July 2009. During this time period, Respondent was assigned as a registered nurse to Santa Rosa Memorial Hospital in Santa Rosa, California. Respondent's contract at Santa Rosa Memorial Hospital was terminated on or about July 22, 2009.

23. On or about July 19, 2009, two nurses on duty at Santa Rosa Memorial Hospital discovered a discrepancy on the Pyxis machine which indicated that 12 milligrams of Oxycodone were missing. The Pyxis machine is a medication dispensing system that automates the distribution, tracking, management, and control of medications. Pyxis machines are usually placed in patient care areas of hospitals and they dispense unit doses of drugs from locked drawers when a staff member enters their PIN. Once the Oxycodone discrepancy was discovered, a chart audit was performed which traced the discrepancy back to Respondent. On or about July 22, 2009, a chart audit was conducted using the Pandora Anomalous Usage reports and the Electronic Medication Administration Records ("EMAR"). The Pandora Anomalous Usage reports are routine, periodic reports generated by Santa Rosa Memorial Hospital's Pharmacy Department through internal audits to show medication usage trends. The July 22, 2009 audit was conducted for seven patients between May 2009, and July 2009. The audit revealed that during this period, Respondent removed a total of 38 medications from the Pyxis machine, including: Norco, Lortab, Percocet, Lorazepam, Hydromorphone, Oxycodone, and Morphine Sulfate. There were several instances of no documentation in the EMAR, of no waste recorded on the Pyxis, and of wrong charting time entries. The audit revealed that Respondent had a pattern of missing or unaccounted for doses of narcotics. Respondent accessed controlled

substances and failed to account for their disposition on the EMAR or any other hospital record. The following are examples of Respondent's narcotic discrepancies and inconsistencies revealed by the audit:

PATIENT A

a. On or about May 28, 2009, at 7:49 a.m., Respondent removed a 10/325 milligram tablet of Norco for Patient A, as recorded by the Pyxis record. Respondent did not chart the Norco as "given" in the EMAR until almost 30 minutes later, at 8:15 a.m.

b. On or about May 28, 2009, at 10:16 a.m., Respondent removed a 10/325 milligram tablet of Norco for Patient A, as recorded by the Pyxis record. Respondent charted the Norco as "given" in the EMAR at 8:34 a.m., nearly two hours prior to removing it from the Pyxis.

c. On or about May 28, 2009, at 3:13 p.m., Respondent removed two 10/325 milligram Norco tablets for Patient A, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the two tablets of Norco in the EMAR or any other hospital record.

PATIENT B

d. On or about June 17, 2009, at 9:47 a.m., Respondent removed two 10/325 milligram Percocet tablets for Patient B, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the two tablets of Percocet in the EMAR or any other hospital record.

e. On or about July 17, 2009, at approximately 9:31 a.m., Respondent removed two 10/325 milligram Percocet tablets for Patient B, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the two tablets of Percocet in the EMAR or any other hospital record.

f. On or about July 18, 2009, at approximately 6:46 a.m., Respondent removed two 10/325 milligram Percocet tablets for Patient B, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the two tablets of Percocet in the EMAR or any other hospital record.

g. On or about July 18, 2009, at approximately 1:02 p.m., Respondent removed two 10/325 milligram Percocet tablets for Patient B, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the two tablets of Percocet in the EMAR or any other hospital record.

h. On or about June 17, 2009, at 9:46 a.m., Respondent removed two 1 milligram tablets of Lorazepam for Patient B, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the two tablets of Lorazepam in the EMAR or any other hospital record.

i. On or about July 17, 2009, at 9:30 a.m., Respondent removed two 1 milligram tablets of Lorazepam for Patient B, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the two tablets of Lorazepam in the EMAR or any other hospital record.

j. On or about July 18, 2009, at 1:02 p.m., Respondent removed two 1 milligram tablets of Lorazepam for Patient B, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the two tablets of Lorazepam in the EMAR or any other hospital record.

PATIENT C

k. On or about July 1, 2009, at 7:40 a.m., Respondent removed 15 milliliters of Lortab Elixir for Patient C, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the 15 milliliters of Lortab Elixir in the EMAR or any other hospital record.

l. On or about June 30, 2009, at 8:41 a.m., Respondent removed 2 milligrams of Hydromorphone for Patient C, as recorded by the Pyxis record. Respondent charted 1 milligram as given at 9:18 a.m., almost 40 minutes later. Respondent failed to chart the disposition or wastage of the remaining 1 milligram of Hydromorphone in the EMAR or any other hospital record.

m. On or about June 30, 2009, at 4:36 p.m., Respondent removed one 10/325 milligram tablet of Norco for Patient C, as recorded by the Pyxis record. Respondent failed to chart the

medication administration of or otherwise account for the tablet of Norco in the EMAR or any other hospital record.

PATIENT D

n. On or about July 4, 2009, at 9:26 a.m., Respondent removed 2 milligrams of Ativan for Patient D, as recorded by the Pyxis record. Respondent charted 1 milligram as given at 10:01 a.m., over 30 minutes later. Respondent failed to chart the disposition or wastage of the remaining 1 milligram of Ativan in the EMAR or any other hospital record.

o. On or about July 4, 2009, at 2:07 p.m., Respondent removed 2 milligrams of Ativan for Patient D, as recorded by the Pyxis record. Respondent charted 1 milligram as given at 3:08 p.m., over one hour later. Respondent failed to chart the disposition or wastage of the remaining 1 milligram of Ativan in the EMAR or any other hospital record.

p. On or about July 5, 2009, at 11:04 a.m., Respondent removed 2 milligrams of Ativan for Patient D, as recorded by the Pyxis record. Respondent charted 1 milligram as given at 11:08 a.m., but failed to chart the disposition or wastage of the remaining 1 milligram of Ativan in the EMAR or any other hospital record.

q. On or about July 5, 2009, at 4:04 p.m., Respondent removed 2 milligrams of Ativan for Patient D, as recorded by the Pyxis record. Respondent charted 1 milligram as given at 4:37 p.m., over 30 minutes later. Respondent failed to chart the disposition or wastage of the remaining 1 milligram of Ativan in the EMAR or any other hospital record.

r. On or about July 9, 2009, at 5:39 a.m., Respondent removed 2 milligrams of Ativan for Patient D, as recorded by the Pyxis record. Respondent charted 1 milligram as given at 6:17 a.m., almost 40 minutes later. Respondent failed to chart the disposition or wastage of the remaining 1 milligram of Ativan in the EMAR or any other hospital record.

s. On or about July 9, 2009, at 11:23 a.m., Respondent removed 2 milligrams of Ativan for Patient D, as recorded by the Pyxis record. Respondent charted 1 milligram as given at 12:00 p.m., over 30 minutes later. Respondent failed to chart the disposition or wastage of the remaining 1 milligram of Ativan in the EMAR or any other hospital record.

t. On or about July 15, 2009, at 11:13 a.m., Respondent removed 2 milligrams of Ativan for Patient D, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the Ativan in the EMAR or any other hospital record.

PATIENT E

u. On or about July 3, 2009, at 9:30 a.m., Respondent removed 120 milligrams of Oxycodone for Patient E, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the Oxycodone in the EMAR or any other hospital record.

PATIENT F

v. On or about July 17, 2009, at 5:32 a.m., Respondent removed 2 milligrams of Lorazepam for Patient F, as recorded by the Pyxis record. Respondent charted 0.5 milligrams as given at 5:58 a.m., almost 30 minutes later. Respondent failed to chart the disposition or wastage of the remaining 1.5 milligrams of Lorazepam in the EMAR or any other hospital record.

w. On or about July 19, 2009, at 7:53 a.m., Respondent removed 2 milligrams of Lorazepam for Patient F, as recorded by the Pyxis record. Respondent charted 0.5 milligrams as given at 8:33 a.m., forty minutes later. Respondent failed to chart the disposition or wastage of the remaining 1.5 milligrams of Lorazepam in the EMAR or any other hospital record.

x. On or about July 17, 2009, at 5:31 a.m., Respondent removed one 325/5 milligram tablet of Norco for Patient F, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the Norco in the EMAR or any other hospital record.

y. On or about July 18, 2009, at 8:02 a.m., Respondent removed one 325/5 milligram tablet of Norco for Patient F, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the Norco in the EMAR or any other hospital record.

z. On or about July 17, 2009, at 5:32 a.m., Respondent removed two milligrams of Hydromorphone for Patient F, as recorded by the Pyxis record. Respondent charted 0.5 milligrams as given at 5:58 a.m., almost 30 minutes later. Respondent failed to chart the

disposition or wastage of the remaining 1.5 milligrams of Lorazepam in the EMAR or any other hospital record.

aa. On or about July 19, 2009, at 7:52 a.m., Respondent removed two milligrams of Hydromorphone for Patient F, as recorded by the Pyxis record. Respondent charted 0.5 milligrams as given at 8:33 a.m., over 40 minutes later. Respondent failed to chart the disposition or wastage of the remaining 1.5 milligrams of Lorazepam in the EMAR or any other hospital record.

PATIENT G

bb. On or about July 19, 2009, at 8:31 a.m., Respondent removed 2 milligrams of Morphine for Patient G, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the Morphine in the EMAR or any other hospital record.

cc. On or about July 19, 2009, at 9:50 a.m., Respondent removed 2 milligrams of Morphine for Patient G, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the Morphine in the EMAR or any other hospital record.

dd. On or about July 18, 2009, at 8:44 a.m., Respondent removed 15 milligrams of Oxycodone for Patient G, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the Oxycodone in the EMAR or any other hospital record.

ee. On or about July 19, 2009, at 5:23 a.m., Respondent removed 15 milligrams of Oxycodone for Patient G, as recorded by the Pyxis record. Respondent failed to chart the medication administration of or otherwise account for the Oxycodone in the EMAR or any other hospital record.

FIRST CAUSE FOR DISCIPLINE
(Unprofessional Conduct)
(Bus. & Prof. Code § 2761, subd. (a))

24. Complainant realleges the allegations set forth in paragraphs 22 and 23 and its subparts above, and incorporates them is fully set forth.

25. Respondent has subjected his registered nurse license to disciplinary action under Code section 2761, subdivision (a), in that Respondent engaged in unprofessional conduct when he failed to document or record the administration or disposition of controlled substances and made other grossly inconsistent entries in patient records as set forth in paragraphs 22 and 23 and its subparts, above.

SECOND CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Incompetence or Gross Negligence)
(Bus. & Prof. Code § 2761, subd. (a)(1))

26. Complainant realleges the allegations set forth in paragraphs 22 and 23 and its subparts above, and incorporates them is fully set forth.

27. Respondent has subjected his registered nurse license to disciplinary action under Code section 2761, subdivision (a)(1), in that Respondent's conduct described in paragraphs 22 and 23 and its subparts above constitutes incompetence or gross negligence in carrying out usual certified or licensed nursing functions.

THIRD CAUSE FOR DISCIPLINE
(Unprofessional Conduct – Unlawfully Obtain or Possess Controlled Substances)
(Bus. & Prof. Code §§ 2761, subd. (a), 2762, subd. (a), 4060)

28. Complainant realleges the allegations set forth in paragraphs 22 and 23 and its subparts above, and incorporates them is fully set forth.

29. Respondent has subjected his registered nurse license to disciplinary action under Code section 2761, subdivision (a), as defined by Code section 2762, subdivision (a), in that he unlawfully obtained controlled substances in violation of Code section 4060, as described in paragraphs 22 and 23 and its subparts, above. The circumstances are as follows:

a. Respondent unlawfully obtained and possessed controlled substances in violation of Code section 4060.

b. Respondent unlawfully obtained controlled substances by fraud, deceit, misrepresentation, subterfuge and/or by the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a).

c. Respondent unlawfully obtained and possessed dangerous drugs by making a false statement in a prescription, order, report, or record, in violation of Health and Safety Code section 11173, subdivision (b).

d. Respondent possessed controlled substances without the written prescription of a physician, dentist, podiatrist, or veterinarian licensed to practice in this state, in violation of Health and Safety Code section 11350, subdivision (a).

e. Respondent administered controlled substances classified as Schedule II and failed to make a record as to the transaction showing the date, name and strength, and the quantity of controlled substances involved, in violation of Health and Safety Code section 11190.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – False, Grossly Incorrect, or Unintelligible Entries)
(Bus. & Prof. Code §§ 2761, subd. (a), 2762, subd. (e))

30. Complainant realleges the allegations set forth in paragraphs 22 and 23 and its subparts above, and incorporates them is fully set forth.

31. Respondent has subjected his registered nurse license to disciplinary action under Code section 2761, subdivision (a), as defined by Code section 2762, subdivision (e), in that he made false, grossly incorrect, or unintelligible entries in hospital, patient, or other records pertaining to controlled substances and/or dangerous drugs, as described in paragraphs 22 and 23 and its subparts, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 600886, issued to Steven Oren Lueder;

2. Ordering Steven Oren Lueder to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 6/1/2011

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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